

The Role for Insurance Mechanisms in Improving Access to Private Sector Primary & Reproductive Health Care

*Technical Advisory Group Meeting
September 12, 2000*

**Deloitte
Touche
Tohmatsu**

IN PARTNERSHIP WITH

Abt Associates Inc.

Population Services International

Meridian Group International, Inc.



FUNDED BY

US Agency for International Development

USAID Contract No. HRN-C-00-98-00039-00

COMMERCIAL MARKET STRATEGIES

1001 G Street, N.W. Suite 400W

Washington, D.C. 20001-4545

Telephone: (202) 220-2150

Fax: (202) 220-2189

Web: www.cmsproject.com

Prepared by Rich Feeley

Issued November 22, 2000

Contents

EXECUTIVE SUMMARY . . . . .	.I
INTRODUCTION . . . . .	.4
BACKGROUND OVERVIEW . . . . .	.5
Patterns of Health Spending . . . . .	.5
Patterns of Contraceptive Use . . . . .	.7
Existing Patterns of Insurance Coverage . . . . .	.9
CRITICAL QUESTIONS . . . . .	.10
1. Can health insurance schemes overcome problems of adverse selection and turnover to reach lower income consumers with a reasonably priced benefit package? . . . . .	.10
2. Can reproductive health and preventative services be included in insurance mechanisms? . . . . .	.12
3. Will health insurance mechanisms change traditional patterns of service provision and utilization? . . . . .	.13
4. Do high marketing and administrative costs prevent the offering of plans with a reasonable benefit package which are affordable to the target groups? . . . . .	.14
5. How can health insurance mechanisms handle the costs of endemic diseases (such as HIV /AIDS and malaria)? . . . . .	.16
6. Is the timetable for starting a health insurance scheme incompatible with the timetable for foreign assistance projects like CMS? Can CMS do anything useful to foster the development of insurance plans within two to five years? . . . . .	.17
CONCLUSION . . . . .	.17
Targets for Supporting Health Insurance Mechanisms . . . . .	.17
The Contribution that CMS Can Make . . . . .	.18
Specific Steps for CMS . . . . .	.20
APPENDIX A — GLOSSARY OF TERMS . . . . .	.21
APPENDIX B — LIST OF PARTICIPANTS . . . . .	.25

Executive Summary

The Commercial Market Strategies (CMS) Project is a USAID funded project working with the private and commercial sectors to increase the use of high-quality family planning and other health products and services in developing countries. One area in which CMS focuses is health financing alternatives. This includes working with both non-profit, for-profit and community based pre-payment schemes. The purpose being to increase access to affordable, quality reproductive and other health services by low and middle income consumers.

Although there are articles in the literature on the experience of various pre-payment schemes, much of what is known about “what works” and “what does not work” is held in the minds of those who have worked with successful, and unsuccessful, health insurance schemes. In order for the CMS Project to determine if health insurance and pre-payment could be a useful part of the overall CMS strategy to expand private sector provision of services, CMS convened a panel of experts with experience in developing country health insurance schemes (A list of participants is attached as Appendix B). The experts were asked to share their experience to determine:

- if health insurance or prepayment schemes including primary care and reproductive health benefits could be successful in developing countries
- if such schemes can serve societal groups targeted by USAID (low income groups including rural populations)
- if including reproductive health in the benefit package increases contraceptive prevalence and/or shifts the insureds away from the use of government family planning services
- the attributes of successful prepayment or insurance programs
- the conditions (geographic, economic, and social) in which programs offering primary and reproductive health care will be most likely to succeed, and
- the types of assistance (which CMS might provide) that will be most useful to nascent health insurance schemes.

The workshop was held in Washington on September 13, 2000 and was attended by staff from USAID and the CMS Project. The Panel addressed a list of specific questions, outlined in the Introduction. The conclusions reached from their experience and summarized here will be used by CMS as it considers health-financing projects in target countries.

The panel concluded that it is possible for private health insurance mechanisms to reach USAID target populations in some developing countries. Risk pooling through a viable health insurance plan has the potential to improve access to health care and reduce the extent to which families are further impoverished by the costs of disease. Such plans can include primary care and reproductive health benefits, and thus encourage private providers to offer these services in their offices and clinics. However, inclusion of reproductive health benefits in insurance plans is unlikely to greatly affect patterns of contraception in the short to medium term.

To be viable, insurance mechanisms reaching low-income groups must:

- cap total benefits, excluding tertiary care and/or setting a maximum on total hospital payments
- enroll a substantial percentage of the eligible group, and
- anticipate and control possible fraud, including providing for verification of membership (photo IDs).

There are two ways in which viable plans can develop:

- by moving down market from higher option plans which serve a higher income market, and
- by organizing around an existing provider, employer, or social group which can persuade a substantial percentage of those eligible to enroll.

Private health insurance mechanisms are most likely to develop where the following conditions are met:

- target populations are already paying substantial sums for health care
- government services are of poor quality, are unavailable, or formally charge substantial prices, and
- regulatory barriers are non-existent, or regulators do not view nascent health plans in the same light as full-fledged insurance companies.

In countries where public health services or Social Security provide adequate quality care for low-income groups at low out-of-pocket costs, plans focused on the USAID target population are not likely to succeed. The greatest potential for community prepayment schemes appears to be in Africa, where government health services are in disarray. The potential for health insurance also seems large in parts of Asia, where private payments already cover more than half of health care spending. Health insurance mechanisms are less likely to form in the more developed countries of Latin America, where Social Security systems cover the middle class and workers in the formal sector of the economy. However, in the poorer countries of Latin America, where Social Security systems are weak, and in communities excluded from the formal sector, there may be some potential for community-based prepayment plans.

Technical assistance continues to be the most highly valued form of foreign aid for health insurance plans. In addition to developing everything from rate structures to benefit packages to financial control systems, experts can assist greatly with risk management or distribution of risks through reinsurance. Books are already in preparation to provide instruction for “mutuelle” type health plans, but little has been done to prepare the private providers or regulators which must deal with health insurance plans. Support in training private providers and regulators would improve the likelihood that health insurance plans develop in a sustainable fashion.

Insurance mechanisms can be viable and still cover locally endemic diseases such as malaria. Caps on total benefits or total days of hospital stay limit the cost from

these diseases. Where HIV is prevalent, however, plans find that they must exclude coverage for this disease. An exception is African Air Rescue; though working in East Africa where AIDS rates are high, it has been able to cover treatment for enrollees in the early stages of the disease. Enrollees seem to accept a limitation on treatment of AIDS because government health services in these countries offer little help to the afflicted. So far, chronic diseases of aging have not proven to be a problem for the health insurance plans represented at the work shop, but the enrolled population is generally quite young.

Traditional health insurers are generally not a target for CMS support. These companies usually offer only indemnity type coverage for major medical risks, and do so as a sideline to life and disability insurance. These insurers are unlikely to cover reproductive health and family planning benefits because the insured “elects” to use these benefits. The target market for these traditional policies is wealthy, and such insurers have no direct relationship with primary care providers. If insurance companies team with foreign managed care organizations and begin to offer broader coverage to a large number of employees (and not just the managerial elite), there may be an opportunity to encourage the inclusion of reproductive health and family planning benefits.

When health insurance mechanisms are sponsored by community groups or medical providers, there is much less resistance to covering primary and reproductive health benefits. When primary and reproductive health benefits are covered, these services help to retain insureds because the enrollees obtain benefits even when they do not suffer from an illness.

Most health insurance plans report administrative and marketing costs in the range of 10% to 20% of premium — generally higher than health insurance plans in developed countries, but still leaving adequate funding for the benefit package. At the lower end of this cost range, plan administrators are volunteers and enrollment is offered to members of the group without extensive marketing. To keep costs low, administration in such plans is very simple, often paying for all services rendered to enrollees using a single itemized monthly bill submitted by a provider.

The true administrative costs of small health insurance schemes are often understated. Foreign assistance provides extensive technical help in setting up the plans — a major cost not shown in the accounts. Reported costs often exclude the cost of capital needed to create claims reserves; in West Africa, some “mutuelles” have accumulated reserves by requiring members to pay premiums for as much as a year before receiving benefits. Reinsurance is another way of managing risk, but small plans are unsophisticated about the purchase of reinsurance. Some plans (such as the CMS Uganda effort) are obtaining “free” reinsurance as another form of foreign assistance.

Regulators who fail to understand the risks, or the benefits, of health insurance may impose requirements that make it nearly impossible for small plans to organize. Foreign assistance providing technical support can validate developing insurance schemes that face opposition from skeptical government authorities.

HEALTH INSURANCE

For purposes of the workshop, a **health insurance mechanism** was defined as any plan which enrolls a group of individuals and collects regular contributions (premiums or earmarked taxes) from the individual or his employer and pays for a defined package of medical benefits only for those enrolled. Such mechanisms may be organized by commercial or non-profit insurance companies, employers, health providers, or specially formed groups. The definition excludes systems in which the government uses general tax revenues to fund a network of facilities available to all citizens. The discussion also excluded the use of private providers under contract to Government run Social Security health systems.

Introduction

The Commercial Market Strategies (CMS) Project is a USAID funded project working with the private and commercial sectors to increase the use of high-quality family planning and other health products and services in developing countries. One area in which CMS focuses is health financing alternatives. This includes working with both non-profit, for-profit and community based pre-payment schemes, the purpose being to increase access to affordable, quality reproductive and other health services by low and middle-income consumers.

If the private sector is to provide quality primary care and reproductive health services to a reasonably broad segment of the population, financial barriers to access must be minimized. This does not mean that services will be “free.” But the cost at the time of service should not deter patients from seeking necessary primary care and preventive services, including reproductive health services.

One way to reduce the financial barriers to care, and potentially to increase the supply of services through the private sector, would be to implement pre-payment or insurance arrangements that include basic primary and reproductive health care. Such plans would have the additional benefit of pooling risks, so that the economic burden of disease does not fall so heavily on those who are afflicted in a particular year. Research shows that the costs of medical care can drive families into poverty as they are forced to sell productive assets to pay medical bills.

A number of private health insurance experiments have been attempted in the developing world. The PROFIT project sponsored a low cost, limited benefit health insurance package in the Philippines (Healthsaver) based on capitation payments to local providers, PROFIT also supported the development by African Air Rescue (AAR) of a prepaid basic health plan in Nairobi. There are flourishing health insurance programs for the middle class in a few countries, such as the Philippines. Nevertheless, prepayment and insurance account for only a small fraction of private health care spending in developing countries.

Although there are articles in the literature on the experience of various pre-payment schemes, much of what is known about “what works” and “what does not work” is held in the minds of those who have worked with successful, and unsuccessful, health insurance schemes. In order for the CMS Project to determine if health insurance and pre-payment could be a useful part of the overall CMS strategy to expand private sector provision of services, CMS convened a panel of experts with experience in developing country health insurance schemes (see Appendix B for a list of participants). The experts were asked to share their experience by answering the following discussion questions:

1. Can health insurance plans reach low income consumers? Can such plans manage adverse selection and turnover in order to remain viable?
2. Can such plans include reproductive and preventative health services in the benefit package?
3. Will such plans change established patterns of service utilization in the ways sought by CMS? How can technical assistance contribute to changing established health behavior patterns among consumers and providers?
4. Can administrative and marketing costs be kept low enough to provide a reasonable benefit package within affordable premiums?
5. How can health insurance handle endemic diseases?

The participants were also asked to offer advice on:

- the conditions (geographic, economic, and social) in which insurance programs offering primary and reproductive health care are most likely to succeed
- the types of assistance (which CMS might provide) that are most useful to nascent health insurance schemes.

The Workshop was held in Washington on September 13, 2000 and was attended by staff from USAID and the CMS Project. (See Appendix B). The findings, outlined below, will be used by CMS as it considers health-financing projects in target countries.

Background Overview

NOTE: The countries referred to in the following section were selected because they are large, generally representative of the principal regions discussed, and data was readily available in a consistent series.

PATTERNS OF HEALTH SPENDING

Existing patterns of health care spending are important in determining if a private sector health insurance mechanism might be viable. In the long term, health care spending is elastic with respect to national income; the total percentage of GDP spent on health care usually grows as per capita income grows. Brazil observed a notable increase, with the proportion of GDP spent privately on health care increasing from 2.1 % to 4.9% between World Bank reports in 1994 and 1999 (see fig.1).

On the other hand, when per capita incomes stagnate or fall, as in Thailand after 1997 and in Turkey after 1990, public health care spending is less elastic than private spending. As family income falls, individuals are less able to pay health care costs, and the relative burden on the public health sector increases. Private

Fig. 1 — Latin America: Private expenditures grow more rapidly.

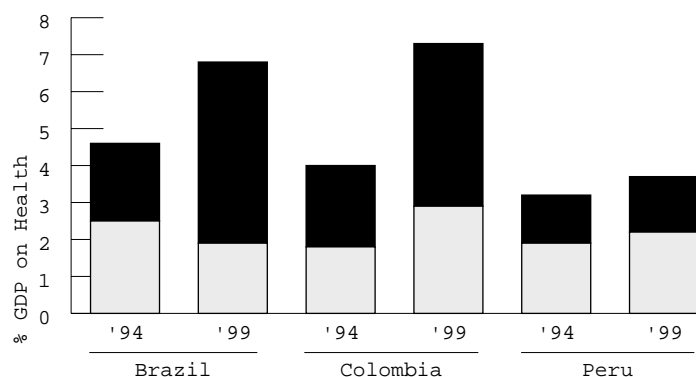
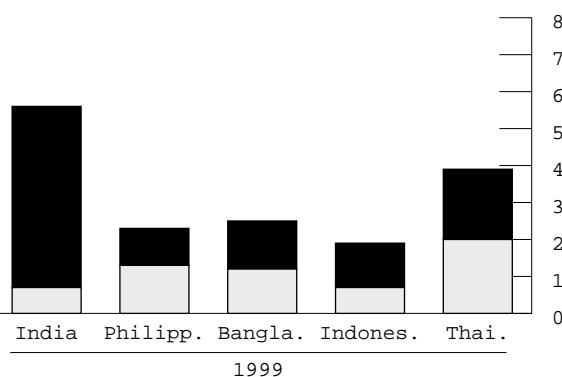


Fig. 2 — Asia: Patients generally pay more than half of health costs.



sector health spending in Thailand fell from 3.9% of GDP to 1.9%, while the public sector expanded from 1.1% to 2.0%.

In Latin America, despite the presence of Social Security systems, private health spending has generally been growing as a percentage of the total, with Colombia now spending 4.4% of GDP privately, while an additional 2.9% is spent publicly. For Brazil and Colombia, total health care spending is nearing the lower end of the range of health expenditure in developed countries (generally 7% to 11% of GDP, when the U.S. is excluded). However, Peru, a poorer Latin American country, spends only 3.7% of GDP on health, with more than half of that spending by the government (see fig.1).

In Asia, the total proportion of national income spent on health care is lower than in the wealthier countries of Latin America. Figure 2 shows only the most recent data because the mix of public and private expenditure has generally been stable. The exception is Thailand, where private health spending dropped significantly in the wake of the 1997 crash. India, with 5.6% of GDP spent on health, had the highest percentage of the five countries reviewed (India, Philippines, Bangladesh, Indonesia, Thailand). For the others, 2% to 4% was the range in the most recent data. Of these countries, only Thailand, then in the heart of a severe recession, reported more than half of health spending from public sources. India showed the largest reliance on private spending — 4.9% of GDP, compared to reported public health spending equal to only 0.7% of GDP.

LEGEND

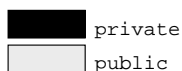


Fig. 1-4

'94 — data from *World Development Report* (1990 data), The World Bank, 1994.

'99 — data from *World Development Indicators* (1997 data), The World Bank, 1999.

In Africa, health spending as a percentage of GDP was also well below Latin American levels; 2.9% in Kenya, 4.7% in Zimbabwe and 3.9% in Uganda. In Zimbabwe, private spending was much more than half the total, but public payments were larger than private payments in Uganda and Kenya. Only in Nigeria, with low total spending on health (1% of GDP), was private spending clearly dominant — 0.7% of GDP compared to .2% of GDP spent by public sources (see fig.3).

In the two large Middle-eastern economies reviewed (Egypt, Turkey), total health spending was just below 4% of GDP. Both countries offer Social Security health coverage to workers in the modest formal sector of the economy. In Egypt, private

Fig. 3 — Africa: Patients pay when governments cannot/will not.

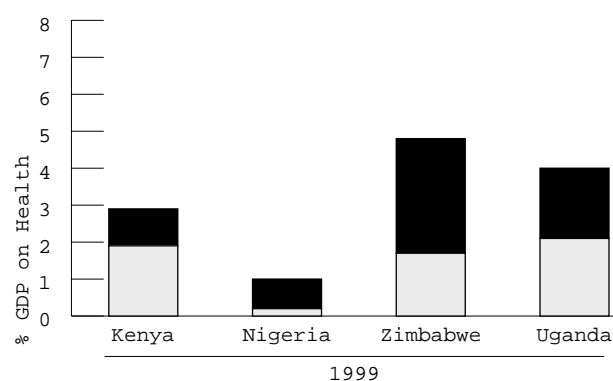
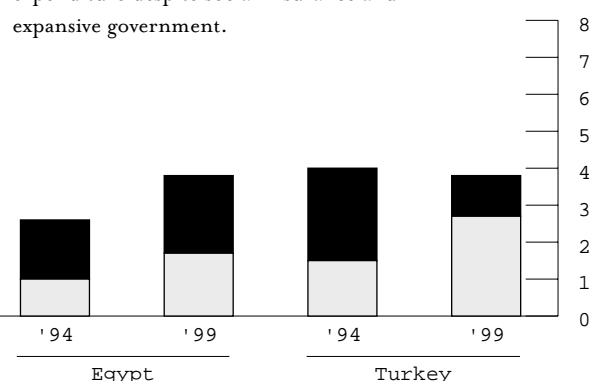


Fig. 4 — Egypt & Turkey: Substantial private expenditure despite social insurance and expansive government.



spending was slightly greater than public spending. In Turkey private spending had been much larger than public spending in the 1994 World Development Report (2.5% vs. 1.5%). In the most recent data, private spending fell back to 1.1% of GDP while the public sector shouldered a greater burden, funding 2.7% of GDP for health care (see fig.4).

In most parts of the world, private spending on health equals or exceeds public funding. There would seem to be a possibility of “pooling” substantial volumes of private spending so as to improve access to care and cushion the cost of illness to individual households. This potential is highest in Asia, less promising in those countries that already have social security systems covering health care. In Africa, absolute levels of private spending are lower, but the inability of government to deliver adequate health care services suggests some potential for private sector insurance mechanisms. It is here, in Africa, that a number of the *mutuelles* and community programs discussed at the workshop have grown.

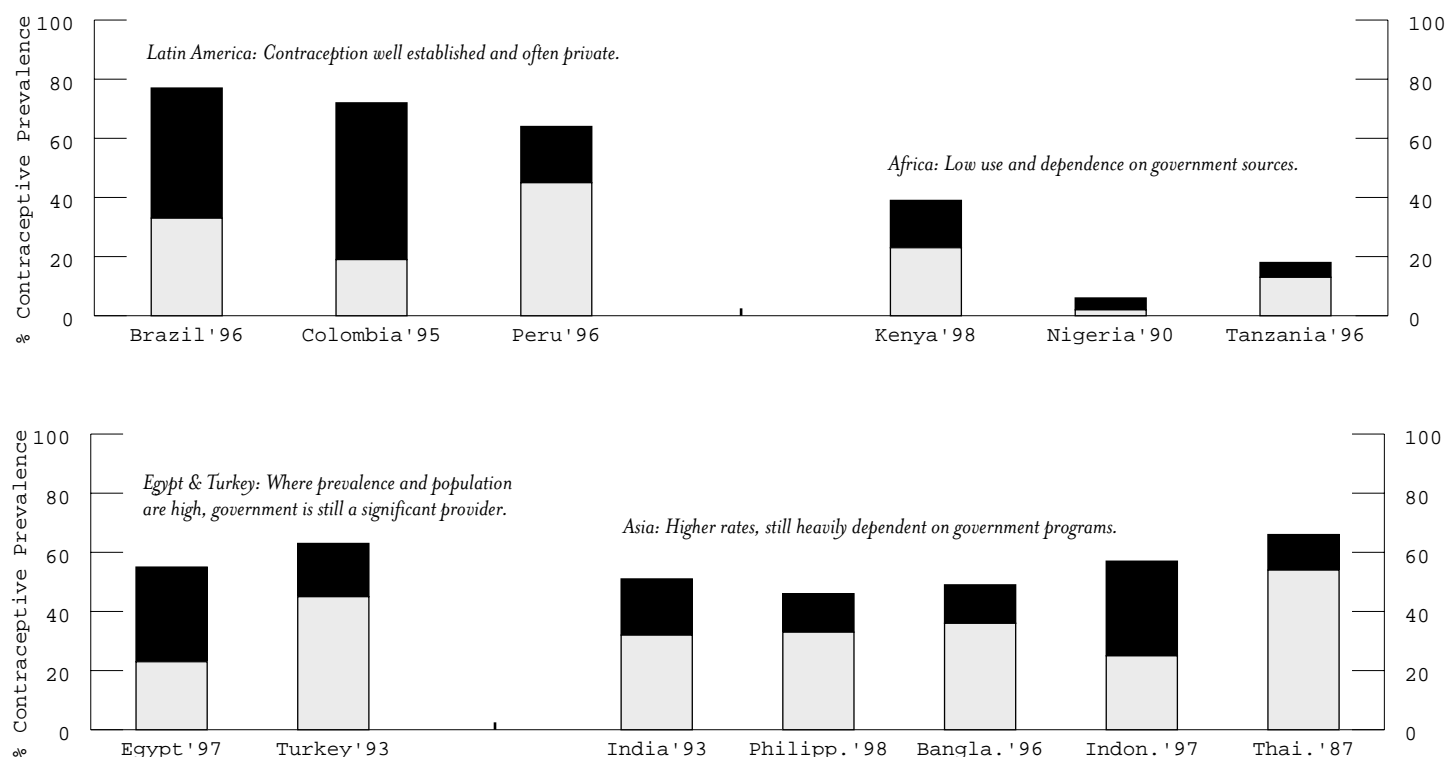
PATTERNS OF CONTRACEPTIVE USE

To determine if health insurance mechanisms could expand private sector funding of reproductive health — a major goal of the CMS project — we must first look at patterns of contraceptive use and funding (see fig.6, next page). The need to expand reproductive health services is great. In sub-Saharan Africa, demand for contraception is expected to grow by 170% in the next 15 years.¹ In India and the Islamic world, rates of growth in demand of 50% to 80% are expected in this period (Ibid). Demand will grow rapidly because the number of women of reproductive age is growing rapidly, while levels of contraceptive usage are still increasing. Governments will likely not have the revenue to fund these huge increases in demand for contraception.

In the countries of Latin America, contraceptive usage is already high (77% in Brazil, 72% in Colombia, 64% in Peru) and the population is growing more slowly. Of the three countries reviewed, only in Peru is the public sector the dominant source of contraception. The potential for health insurance to increase utilization of contraception in Latin America is limited. Non-users are likely

1. *Profiles for Family Planning and Reproductive Health Programs*, Futures Group, 1999

Fig.6 — The Pattern of Payment for Contraception



concentrated in the poorest economic groups, which are most difficult to reach through insurance schemes. In Peru, the Government provides more than half of health care funding and 70% of the funding for contraception. A successful insurance scheme would reduce the burden of government funding for contraception only if it could shift users from public to private sources.

In Asia, contraception rates in the five countries reviewed varied between 41% (India) and 66% (Thailand). Although private spending for curative services is high, public funds are the dominant source of support for contraception. The exception is Indonesia, where 25% of the population received publicly supported contraception and 32% purchased the service or supplies privately. Even if health insurance has substantial potential to pool private sector health spending and improve access to primary care, such plans will face a difficult task in shifting users away from traditional government sources of contraception.

In Africa, where contraceptive use rates are the lowest of any continent, governments are still the dominant funding source. Nigeria is an exception because reproductive health, like all health care, receives little government funding and the private sector is dominant. With only 6% of Nigerian couples using contraception, demand in the private sector might "take off" if there were a shift in cultural attitudes. This could be marginally helped by insurance schemes which capture private funds and improve access to care, including reproductive health. If insurance schemes are to expand the provision of private sector reproductive health services in Africa, such plans must change the attitudes of

LEGEND

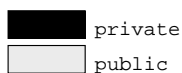


Fig. 6
All data from *Profiles for Family Planning and Reproductive Health Programs*, Futures Group, 1999.

enrollees, as well as shifting the locus for receipt of contraceptive services away from the public sector. Panelists were skeptical that insurance coverage alone can increase contraceptive prevalence and shift users away from government sources of family planning. Changing cultural attitudes towards contraception is not a job that medical providers readily undertake. Existing contraceptive users will shift from traditional sources of family planning only if the provider aggressively informs them of the availability of such services in the insured benefit.

EXISTING PATTERNS OF INSURANCE COVERAGE

Data on the extent of existing private sector health insurance mechanisms, or the potential market for such schemes, is fragmented and inconsistent. The private sector is active within the social security systems of Chile and Argentina, and in providing health insurance in Brazil. Medical aid societies are a major factor in South Africa and Zimbabwe. In the Philippines, even with low levels of private health care spending, approximately 2,000,000 people (2.7% of the population) are enrolled in private health insurance plans or HMOs.

Until very recently, “health insurance” in developing countries has been limited to indemnity insurance offered as a sideline by traditional insurers trying to obtain life and disability insurance business. Under these indemnity plans, the insurance company compensates the insured for a portion of the medical bills incurred. There is no direct relation between the insurer and provider that could be used to upgrade or reform service provision. Insurers seek to contain risks by excluding medical conditions and individuals with the potential to generate excessive claims. The covered benefits usually exclude preventive and reproductive health care on the grounds that the middle class insureds can afford such services, and because the insurer covers only health care “casualties” beyond the immediate control of the insured. In addition, insurers have a concern about “moral hazard” — the tendency for the insured to increase the use of services because they are covered. This concern manifests itself by the insurers’ reluctance to cover preventative and reproductive health due to their fear that the insured will take advantage of these benefits, thereby increasing the cost to the insurer.

Market estimates for private health insurance tend to focus on these traditional products offered by insurance companies, or on managed care products offered more recently to higher income groups and employers. These estimates suggest that up to 10% of a population might purchase health insurance products. However, few markets report that more than 2% or 3% of the population are now enrolled. In most countries, current participation is much less. In India, with very high levels of private health expenditure, only 2,500,000 people are enrolled in private sector schemes — about 0.25% of the population. Restrictions on entry into the Indian insurance market and very high capitalization requirements for health insurers explain why there are so few policyholders compared to the Philippines.

The “health insurance market” as measured by most investment analysts will likely not extend directly to the individuals that USAID wants to reach. “Traditional” health insurance policies will only meet USAID and CMS objectives if they shift

current middle class contraceptive users away from government services and free up public funds to improve services for the impoverished.

The way to directly extend the benefits of health insurance further down the socioeconomic scale is to offer plans with limited benefits that include primary and reproductive health care. These plans must have low administrative costs, simple premium payments, minimal marketing expense, and strong deterrents to adverse selection. The *mutuelles*, and prepaid plans organized around private sector providers that serve a poorer population, may meet these requirements. Africa seems to have the greatest potential for development of such schemes, in part because government-funded health care is unavailable or of low quality. Patients are already using private providers and paying for services. Such programs are not easy to start and sustain. There must be a “social entrepreneur” to organize the beneficiary group. The group size is usually small. Where the plans have worked, they have not always internalized the costs of the technical assistance which keeps them running. African Air Rescue (AAR) is an exception, and it has been able to move down market from a high end clientele which generated profits to fund this development.

Though the premiums which a community based prepayment scheme can charge in Africa are small, and the benefit package must be limited, the alternatives to such plans may be worse. Often, government does not provide services. When there is no risk pool for private health expenditures, the sickest go without needed care or further impoverish themselves to purchase it. Given these unpalatable choices, foreign assistance should support further experiments with *mutuelles* and provider-based plans.

Critical Questions

The panel reviewed a series of questions that are vital to determining the viability of health insurance mechanisms, and to deciding if health insurance has a place in the CMS portfolio of projects. The questions were addressed individually by the panelists as follows:

1. CAN HEALTH INSURANCE SCHEMES OVERCOME PROBLEMS OF ADVERSE SELECTION AND TURNOVER TO REACH LOWER INCOME CONSUMERS WITH A REASONABLY PRICED BENEFIT PACKAGE?

Affordable plans can reach consumers in social classes C and D with an affordable benefit package, but the plan must employ a variety of techniques to survive. Mandatory membership from an eligible group reduces adverse selection. This is often difficult to achieve. Basing the plan on an employee group is desirable. To prevent abuses by “unenrolled” family members, some plans have required that all beneficiaries be determined at the time of initial enrollment — family members (other than newborns) cannot be added later. Discounts to the “per person” premium may be offered to the additional family members enrolled. Offering a single enrollment “window” to a prospect may also discourage patients from

waiting until they suspect disease to enroll in a plan. Photo ID cards are necessary to avoid abuse by those who do not pay premiums.

Primary care and reproductive health services can discourage high turnover in a plan. Members drop out if they are not ill and feel they are getting no benefit for the premiums paid. If they get preventive services, they are more likely to feel that they are benefiting and stay in the plan.

Marketing a private plan is difficult where the government offers an accessible service of acceptable quality at lower cost. A prepaid plan built around a facility in Mexico City survived until the government opened a competing clinic in the same neighborhood. With lower prices in the government clinic, the enrollment in the private facility plan melted away.

AAR started its plan in the cities, and thinks that similar plans stand a better chance where there is substantial formal employment. It would not have been possible for AAR to start its own "prepaid clinics" outside a major employment center like Nairobi. AAR was also able to build down from its initial higher income target market towards lower income employees. The AAR outreach centers available in communities where workers live make the plan more attractive, and are part of the primary care package. To expand beyond major urban centers will require a different focus, such as franchising private clinics to become part of a network.

Several panelists commented on the typical utilization curve in a new plan: a short lag after start up as enrollees learn about available services, followed by a burst of activity as pent up demand for medical intervention is met. Then, when enrollment has been stable for a while, utilization falls back to lower levels. A new plan must be capitalized to get through the "high utilization" period, and this must be taken into account in financial planning. In some West African mutuelles, members pay premiums for as much as a year before they can receive services; in effect, the plan is capitalized by the beneficiaries.

All panelists agreed that the benefit package required in a developed country is not viable in these markets. Benefits must be capped, either by excluding certain conditions or treatments, or by setting limits on the use of services. Many mutuelles limit the number of hospital days for which they will pay. Benefit packages often exclude services beyond the selected primary care hospital, thus effectively excluding referral care. Age-related chronic diseases have not yet proven to be a major problem for insured groups, but this may change as populations age. Many plans exclude treatment for AIDS or its consequences where the disease is endemic. Although seemingly discriminatory, the AIDS exclusion is understood, and often requested by, beneficiaries. They recognize that the treatment of AIDS would make the benefit package unaffordable. AAR (see below) suggested a way in which a "partial" AIDS benefit might be made available in lower cost plans.

2. CAN REPRODUCTIVE HEALTH AND PREVENTATIVE SERVICES BE INCLUDED IN INSURANCE MECHANISMS?

Panelists were unanimous in concluding that such services can be offered in an affordable benefit package, and that most beneficiaries want such services. While community and provider groups that sponsor plans are receptive to including reproductive health benefits, traditional insurance companies are not.

Life and casualty insurers have traditionally opposed including reproductive health and family planning benefits, alleging they are subject to “moral hazard” and not to chance events beyond the control of the insured. These companies are unwilling to cover any benefit that appears to be subject to beneficiary choice, rather than the result of accident or disease. Their target market has sufficient discretionary income to buy these services, and is probably doing so already. Executives coming from a background of liability, casualty and life insurance see costs escalating if a policy offers benefits that customers already purchase. Rather than thinking of comprehensive health coverage, these executives analogize the situation to using automobile insurance to pay for an oil change, or new tires.

Any change in attitude from these insurance companies will come slowly. They are potential partners for CMS only if they are teamed with foreign insurers or local providers who understand the merits of a benefit package including primary care. Some schemes — such as the *mutuelles* — specifically avoid characterizing the prepaid health product as insurance. In the West African setting, consumers have a very negative view of insurance and insurance companies, often derived from bad experience with motor vehicle policies.

A bias against covering reproductive health and primary care benefits (particularly maternity and pre-natal care) arises when the benefit package is chosen by men and women beyond reproductive age who have no personal need for these services. When women of reproductive age help choose the benefits, they usually welcome the inclusion of reproductive health and primary care. Some *mutuelles* find that enrollees are willing to pay directly for deliveries and exclude them from the benefit package, but these plans include other preventive and reproductive health services. At least one *mutuelle* is being formed in Africa specifically to cover the needs of reproductive age women. Those plans that include reproductive health and primary care have not found these benefits to be an unacceptable drain on premium.

Health providers usually see the merit in offering primary care and reproductive health services. If they already provide such services, prepayment is an improved way of collecting from their existing clientele. Medical providers are also more likely to understand the long term health benefits and cost savings from prevention and early primary care interventions.

To encourage parents to use preventive services, the Uganda cooperatives supported by CMS are waiving co-payment for sick childcare if the child is fully immunized. In Mexico, public agencies compete to see that children are receiving a full package of preventive services, and it is harder for insurance mechanisms to

show value to the consumer by offering preventive care. The same is true for reproductive health care — if government programs of adequate quality are readily available, those considering private insurance will likely not see the benefit of having contraceptive services covered.

Both AAR and United Health Care commented on the potential to improve health status and reduce disease burden by providing preventive services. In some cases, a prepaid provider with a substantial share of the local population might even be motivated to assist in improving water supplies and sanitation in order to reduce the costs of care.

The panel concluded that most plan sponsors — other than traditional casualty and life insurers — are willing to include primary and reproductive health care benefits if the beneficiaries ask for such benefits. None of the panelists felt that these benefits would drive the cost of a plan to unmarketable levels.

Where contraceptive use levels are low (as in much of Africa), the marketing boost from including contraception in the benefit package is minimal, although women who already use contraception may use the benefit if they have been purchasing privately.

3. WILL HEALTH INSURANCE MECHANISMS CHANGE TRADITIONAL PATTERNS OF SERVICE PROVISION AND UTILIZATION?

The panel was skeptical that insurance mechanisms will change existing patterns of contraception. Where beneficiaries already get the service from the insurance provider, they will obtain the service under the benefit plan. A switch from government providers of family planning services will occur only slowly. In the Healthsaver experiment in the Philippines, PROFIT found that few women switched to the pre-paid provider's family planning service. AAR found only a limited amount of switching to its family planning service. The switch will be faster if government clinics charge fees higher than copayments charged by the insurance plan. If products (pills, condoms) are free or subsidized at government clinics, and not covered in the benefit plan, there will be little reason to switch sources of contraception. One way to overcome this would be for the government to provide subsidized product to the insurance schemes. Providing vaccines to pre-paid clinics on the same basis would also facilitate a switch in the source of well child care. While the insurance plan would not be paying the full cost of the vaccine or contraceptive, it would be paying the cost of clinical services previously provided by the Government.

Panelists were even more skeptical that insurance mechanisms will lead to rapid changes in contraceptive acceptance. Use of contraceptives is determined by a complex mix of historical, cultural, and economic factors. Prepayment or insurance have little effect on these factors. In countries where contraceptive prevalence is high, the non-users have strong religious or cultural objections, or are concentrated in disadvantaged groups which are hardest to reach through insurance schemes. Where prevalence is low, social marketing and education must first change attitudes towards contraception, and plan enrollees may then seek such services.

AAR suggested that the long-term relationship between a primary care physician and a woman, which can develop in prepaid plans, gives the opportunity to counsel on reproductive health. Ultimately, this can increase the acceptance of contraception. Such a hypothesis should be tested.

4. DO HIGH MARKETING AND ADMINISTRATIVE COSTS PREVENT THE OFFERING OF PLANS WITH A REASONABLE BENEFIT PACKAGE THAT ARE AFFORDABLE TO THE TARGET GROUPS?

Panelists reviewed the administrative and marketing costs of plans they know. While United Health Care's plans in the U.S. have administrative/marketing costs equal to 12% of premium, plans in the developing world have costs in these categories closer to 20% to 22%. Developing country insurers do not have the volume and the experience to run more efficient claims processing systems, and often seek to acquire administrative systems from a foreign partner.

AAR reported administrative costs of 16% of premium. Mutuelles tend to have lower administrative costs for a number of reasons:

- marketing is limited, and by word of mouth within the group
- many administrative functions are performed by volunteer officers, and
- payment systems are kept simple because of the limited professional staff; for example, providers are paid against a single monthly invoice, not individual claims.

Experience with small mutuelle-type organizations in East and West Africa shows that administrative costs, particularly start up costs, are understated. Technical assistance is often provided by donor agencies and the cost is not included in the accounts of the health plan. This will be a problem in the long run: if small mutuelle-type plans have advantages in marketing and avoiding adverse selection, how can they develop adequate administrative skills without continued technical assistance?

One way to lower start up costs is franchising. A larger and more experienced organization develops benefit packages, provider contracts, and administrative systems, as well as marketing strategies. Reinsurance arrangements can also be part of the franchise package. Plans join such a franchise network without struggling through costly start up traumas. AAR is experimenting with the franchise approach.

Concern arose during the discussions about two types of costs not often categorized as "administrative" or "marketing." Neither is a direct payment for medical services. One is the cost of required reserves or risk transfer mechanisms such as reinsurance. The other is the cost of regulation. If inadequately regulated, insurance schemes may fail and taint the market for future plans. If regulated excessively, promising plans may not reach the target groups that USAID/CMS want to serve.

In the Uganda schemes supported by CMS, the Department of International Development (DFID), the British Aid Agency, has provided a "reinsurance fund." This was necessary to encourage the providers (mission hospitals) to accept pre-

payment. The providers were assured that they would receive partial reimbursement for their costs when utilization exceeded planned levels. The Uganda insurance schemes are not paying anything for this reinsurance, so it represents an unsustainable subsidy.

Hopefully, providers will eventually become comfortable with taking pre-payment risk, as did the hospitals that participated in the Healthsaver scheme in the Philippines. There, hospitals received a comprehensive capitation equal to about 60% of the monthly premium collected. For this amount, the hospital was required to provide the full benefit package, including reproductive and primary health care. Healthsaver had a benefit ceiling that precluded payment for tertiary care. This Philippine plan also had a stiff pre-existing condition exclusion. The project evaluation showed that hospitals did not lose money on care of Healthsaver beneficiaries. Nevertheless, prominent Manila hospitals refused to participate because they were averse to accepting any risk. Healthsaver closed, not because of inadequate pricing for the benefit package, but because the 40% of premium retained by the insurer did not cover the costs of marketing and premium collection. The plan had been sold individually in low-income neighborhoods, and not marketed to groups.

If providers are unprepared to take most of the risk of excessive utilization, the plans must develop reserves (hard to do within feasible premium levels), or find commercial reinsurance. Creation of reinsurance arrangements, or more sophisticated risk sharing mechanisms with providers, may be necessary to make *mutuelles* and the Uganda experiments viable in the long run.

Commercial insurers have the capital to create reserves for claims that exceed projected levels. They also have experience in purchasing reinsurance. Thus, they can solve the reinsurance dilemma. However, these firms are reluctant to move down market to the USAID target population, except when a large employer makes a commitment to provide benefits to its work force.

Without access to investment capital or reinsurance, many West African *mutuelles* develop their own reserves. In essence, many are capitalized by their enrollees. Members are required to contribute premiums for some time, in some cases more than a year, before receiving benefits. These initial collections form the reserve fund. *Mutuelles* which fail to do this, and underestimate utilization, have failed. Capitalizing a scheme through the beneficiaries requires a remarkable degree of commitment and self restraint, and will not likely occur where the government provides services of acceptable quality at low cost.

Some countries have pursued a regulatory strategy knowing that it precludes development of smaller *mutuelle* or provider based plans. Mexico recently adopted regulations that require sizable reserves and prevent insurers from shifting high cost cases to Social Security. Because Mexico has an extensive Social Security health care system covering workers in the formal sector, there is less concern about extending private insurance alternatives to ordinary workers. Mexican regulators focused on the financial stability of plans that are marketed to

higher income employees and employers. They also drafted provisions that prevent the insurers from offloading high cost cases on to the public system.

In countries which lack a strong Social Security system or National Health Service, the Mexican approach to regulation is not appropriate. In environments where government sponsored services are weak, such stringent regulations would be a mistake. Low cost plans can be viable only if they have benefit caps or exclusions. Capital requirements must be sensitive to the small size of these plans, and should not be set very high minimum reserves. Risk sharing mechanisms and reinsurance should be accepted in lieu of higher capitalization. Insurance regulators, as well as insurance executives, must move beyond conventional views of insurance if products are to develop in those countries where public health systems are weak. Regulations should assure that insureds get what they pay for, but should not blindly copy rules enforced against major commercial insurers in more developed economies. Counsel in crafting appropriate health insurance regulations and enforcement strategies is a form of technical assistance which CMS can provide.

5. HOW CAN HEALTH INSURANCE MECHANISMS HANDLE THE COSTS OF ENDEMIC DISEASES (SUCH AS HIV/AIDS AND MALARIA)?

Panelists were nearly unanimous in their conclusion that prepaid plans can cover endemic diseases with one exception. In East Africa, affordable health plans cannot cover the full cost of AIDS care. Neither can government health systems. Recognizing this, many beneficiaries accept, or propose, a limitation on the benefit for AIDS.

The most innovative approach was suggested by AAR, which uses the WHO four stage approach to HIV/AIDS. Benefits are covered while the disease is in the first two stages. Thereafter, AIDS and its associated conditions are not covered. Coverage for drugs to prevent mother-child AIDS transmission may be possible.

The good news is that other diseases can be covered. Even where malaria is endemic, almost all plans provide for its treatment. Some plans would like to consider prophylactic measures, such as subsidizing bednets. Because of the seasonal variability in malaria infections, plans must be financially prepared for the higher levels of utilization in malaria season.

In response to a question, most panelists said that they had not found a problem in covering the chronic diseases that increase in prevalence with advancing age. For most plans, the insured population is still very young. AAR started with a maximum age for enrollment of 60, and terminated coverage at age 65. They now permit enrollees to remain in the plan until age 70, and will be introducing home nursing services and an age-adjusted premium in the future. Since most plans have a benefit cap, the maximum outlay on malaria or a chronic disease is limited. Plans which attempt a more comprehensive benefit package without these caps will face greater financial pressures. If they survive, they may be forced to consider age exclusions or age adjusted rates.

6. IS THE TIMETABLE FOR STARTING A HEALTH INSURANCE SCHEME INCOMPATIBLE WITH THE TIMETABLE FOR FOREIGN ASSISTANCE PROJECTS LIKE CMS? CAN CMS DO ANYTHING USEFUL TO FOSTER THE DEVELOPMENT OF INSURANCE PLANS WITHIN TWO TO FIVE YEARS?

Yes, the panelists concluded. The life cycles of technical assistance and health insurance projects can be compatible. It takes more than two to five years to create a large, stand alone health insurance company. But assistance with a more limited time horizon is valuable. Because so much technical assistance is needed to start a health insurance scheme, there are many ways to help in the start up phase. For many plans, capital is not the most important barrier to start up, so the foreign assistance project need not be a long-term lender or equity investor.

AAR pointed out that an important role for technical assistance is validating the concept for a health insurance plan. Government regulators are woefully untrained and likely to over-regulate. Foreign support to nascent plans, and education of responsible regulators, can ease the start up immensely.

While creation of a major health insurance company is a long term effort, moving an existing organization “down market” to lower option plans serving lower income workers can occur in a shorter period of time. The larger organization has access to management skills and capital, but it does not have the knowledge of provider contracts, benefit design, and risk management which can make a “lower option” plan viable. Therefore, there may be collaborations where foreign assistance can bring an established player into the market. These opportunities are most likely to appear in Asia. Private health care spending is relatively high, per capita incomes are increasing, and managerial capacity is extensive. This is where Untied Health Care is focusing much of its development effort.

In Africa, the recipients of technical assistance are likely to be smaller. AAR, moving down market from an established business, is an exception. Mutuelles can be started in a short period of time where the regulatory regime is friendly (or non-existent). But they are desperate for technical assistance. Perhaps the long-term viability of the mutuelle may not be assured at the end of the technical assistance project. But some successes could be apparent — if the right membership group is chosen and the right technical assistance provided.

Conclusion

TARGETS FOR SUPPORTING HEALTH INSURANCE MECHANISMS

Geographically, the greatest potential seems to lie in Africa and Asia. Although per capita health care spending is low in Africa, the government is usually a weak service provider, and a well run insurance plan can provide better service at an acceptable cost. Quality, as well as price, does count.

In Asia, there are much larger pools of existing private health care spending to be structured into health insurance mechanisms. Such mechanisms must move beyond conventional indemnity insurance to use innovative payment and quality control methods.

Where Social Security systems are strong, as in much of Latin America, the market for private health insurance schemes will be limited. In poorer Latin American countries without strong Social Security systems, there may be some market for mutuelle-type plans if government services are absent, or of poor quality. To prosper, any such plan must be based on a strong pre-existing community group or private provider. It must not confront regulatory standards for benefits or financial reserves equivalent to those imposed in developed countries.

All panelists agreed that support for health insurance mechanisms is, at best, a very indirect way of increasing contraceptive prevalence or shifting users from government services. While primary care and reproductive health services can be included in an affordable benefit package, contraceptive usage patterns will not soon change as a result. The insurer can encourage providers to offer family planning services by funding the benefit, providing training and medical protocols, and even requiring certain classes of provider to offer these services. This may strengthen private sector family planning capacity in the long run. In the short run, improving primary care is a better reason to support health insurance mechanisms. Enlightened managers and most beneficiaries see the advantage to including preventive services. Insurance can lower the barriers to primary care, particularly where competing government services are weak. Support for health insurance mechanisms should be based on achieving broader health system goals, not on a desire to directly impact contraceptive use.

THE CONTRIBUTION THAT CMS CAN MAKE

The most important support CMS can give to developing insurance schemes is technical assistance. "How to" books on starting up mutuelles are already in preparation, but there is a variety of know how required to launch a health insurance scheme, and potential plan sponsors in developing countries have very little of this. Experts are needed to help:

- predict costs on a sound actuarial basis
- develop market intelligence, including input from potential beneficiaries
- design benefit packages, limits and exclusions
- develop financial control and claims processing systems
- select beneficiary identification technology
- develop provider contracts and criteria for selection
- choose provider reimbursement methods, and
- develop protocols for treating common diseases and improving the quality of care.

In addition to a flow of technical assistance from developed to developing countries, there is a need for a "South-South" exchange of information between

plans which do succeed. Some of this exchange is beginning for mutuelles. More could be done to extend the lessons learned by insurers, such as AAR, which have moved down market to cover lower income beneficiaries.

While an infusion of capital, per se, may not be necessary, most schemes will need help in managing the risks inherent in insuring a population against illness. An unexpected epidemic can destroy a well-planned plan unless it has some "catastrophic" protection. Capital for reserves may be part of this protection strategy. So is the sharing of risks with providers, and the reinsurance of excessive risks to commercial reinsurance companies or other more heavily capitalized risk takers. Developing these risk management mechanisms is one of the most important forms of technical assistance.

CMS can also help develop a rational regulatory environment for private health insurance. Support from a project like CMS can validate the concept of prepayment to skeptical government officials. Foreign experts can demonstrate how the chance of default is moderated by the risk management mechanisms selected. In the longer term, education of regulators about the potential, and the risks, in health insurance is a sound investment. This assistance should be targeted to countries where there is a strong potential market, weak government health services, and an uncertain regulatory structure.

Just as regulators need training, so do private sector providers. Most have no idea how to approach a negotiation with an insurance scheme. They do not know how to assess the risk inherent in a particular reimbursement method, or how to compare continued patient payments at the time of service with pre-payment arrangements. The absence of these skills in hospital management was a major problem in the Healthsaver experiment. Many private providers cannot comprehend or implement the quality assurance mechanisms that are a condition for participation in an insurance plan. In Latin America, where there is potential for private providers to contract with Social Security networks, providers do not yet have the experience or training to be a party to negotiations. In addition to "hands on" technical assistance, there is a need for a manual or training materials that providers can use in preparing for negotiations with insurers or Social Security organizations.

Panelists concurred that technical assistance and training are the most valuable contribution from a foreign assistance project like CMS. This assistance can have a visible effect within three to five years in an environment where:

- private health care payments are substantial
- government health services are clearly inferior or are subject to substantial charges
- the sponsor of the proposed plan is a reputable organization which can enroll a substantial group with high percentage participation, and
- regulations are reasonable, or regulators can be educated to sensitively protect consumers while permitting plans which pool risk and private payments in such a way that beneficiaries have improved access to care.

SPECIFIC STEPS FOR CMS

Bearing in mind the lessons learned from this expert panel, CMS should continue to include a consideration of health financing analysis in all country assessment. If other organizations are supporting community pre-payment plans or health insurance experiments, CMS should work to see that family planning and reproductive health services are integrated into the benefit package. CMS can provide assistance in costing such services, in developing treatment protocols, and in training providers who do not currently offer family planning services at a sufficient level of quality.

If the country assessment finds opportunities for community prepayment or health insurance, consideration should be given to including support for such plans in the technical assistance that CMS proposes in the country. Such support can be offered directly to the plan sponsors or insurers, or to providers and regulators working with such plans. In the long run, such assistance will serve CMS strategic objectives if it results in sustainable prepayment plans offering a family planning and reproductive health benefit, with private providers who offer these benefits at a reasonable level of quality as part of their standard service.

Appendix A — Glossary of Terms

The world of health insurance has somewhat fluid definitions for its products and services. The following are offered as working definitions for the Technical Advisory Group (TAG) meeting on September 14th, 2000. These definitions should not be considered as absolutely definitive, but we would like participants to use these terms as defined so we can have a common understanding and a focused discussion.

ADVERSE SELECTION

The phenomenon in which individuals with greater medical needs enroll in a particular insurance mechanisms or risk pool, thus increasing the average health care costs for the group.

COMMUNITY RATING

Practice of setting health insurance premiums according to the total loss experience of all participants in a broad geographic community, possibly with adjustments for sex or age.

COPAYMENT

Payment, in an amount authorized by the plan organizer, made to the provider of health services directly by the patient in addition to payments due to the provider from the insurer or plan organizer. Payable at time of service, in a flat amount, or as a percentage of the approved rate for the service.

DEDUCTIBLE

Total amount which a beneficiary must pay for health care services “out of pocket” as a pre-condition to obtaining payment for further services from the plan organizer or insurer. Usually stated as a fixed amount per annum per beneficiary.

EXPERIENCE RATING

Practice of determining health insurance premiums based upon the loss experience of a particular insured group. Often results in high premiums for small employers or groups.

FORMAL SECTOR

That portion of the economy in which large government or private organizations employ workers according to well-defined terms of employment, with periodic payment of wages or salaries against which taxes or health insurance charges may be assessed.

HEALTH MAINTENANCE ORGANIZATION (HMO)

An organization receiving a fixed periodic payment for delivering a defined package of health services to an enrolled population. Can be based on a single provider or network of providers, and may encompass a variety of reimbursement and management systems. The HMO bears the risk that costs will exceed the defined payments. Such systems should encourage investments in preventive health care. Increasingly regulated as a form of insurance.

INDEMNITY (HEALTH) INSURANCE

An insurance policy in which the insured receives compensation for health expenses after s/he has incurred (paid) them. There is usually no direct relationship between the health insurer and health provider, and the policy often limits payment to treatments for disease or accident, thus precluding payment for many preventive, primary care, or reproductive health services.

INFORMAL PAYMENTS

So called “under the table” payments by patients which are not recorded as income to the organization or practitioner. Originally seen as gratuities, these have become a major source of financing, particularly for public sector organizations and employees no longer adequately supported by public funds or officially collected fees.

INFORMAL SECTOR

That portion of the economy not characterized by structured employer-employee relationships where worker compensation is readily subject to tax or insurance assessments. Includes smallholder agriculture, itinerant labor, merchants and self-employed craftsmen.

INSURANCE MECHANISMS

Any program in which a group of individuals are enrolled in a plan which collects regular contributions (premiums or earmarked taxes) from the individuals or their employers and pays for a defined package of medical benefits only for those enrolled. Such mechanisms may be organized by commercial or non-profit insurance companies, employers, health providers, or specially organized groups. Excludes systems in which the government uses general tax revenues to fund a network of facilities available to all citizens.

MANAGED CARE

Covers a range of programs designed to introduce a note of cost consciousness into an insured physician-patient relationship. Through incentives or controls, the insurer or scheme organizer attempts to make the health care system more cost effective. May include:

- prior approval of elective hospitalization and significant outpatient diagnostic or treatment expenditures
- restricted referral networks
- continued stay review, designed to shorten hospital stays
- gatekeeping arrangements, in which the patient chooses a primary care practitioner (PCP) and the patient must obtain approval from the PCP for a specialist referral, and
- capitation, or other risk sharing arrangements in which a responsible primary care physician, hospital, or specialist receives a flat monthly payment for each enrolled patient, regardless of the amount of care delivered.

MANDATORY HEALTH INSURANCE

Program where the government requires employers and employees to purchase health insurance. Relative employee and employer financial contributions vary. Usually functions by funneling employer/employee payments through commercial insurers or medical aid societies/sickness funds.

MEDICAL AID SOCIETY

Usually in Southern Africa. Non-profit insurance type organization which provides medical benefits to an enrolled population. Usually functions as an insurer, paying medical providers, rather than as a direct provider of services.

MORAL HAZARD

A term used in the insurance industry to characterize a situation where the availability of insurance coverage causes the insured to increase the use of services. For example, if the availability of coverage for orthopedic services encourages a skier to take greater risks knowing that he will incur no medical costs when he breaks a bone.

MUTUELLE

From the French, term applied to a community group which provides certain social or health care benefits to members who pay a fee. Originated as a form of community solidarity offering disability and death benefits, but also provides health benefits in some situations, particularly in Francophone Africa.

OPEN ENROLLMENT

Period of time during which any eligible individual or household may join /switch health insurance plans.

OUT-OF-POCKET PAYMENTS

Payments made out of household assets to a medical care provider by a patient (or his family) at the time a service is rendered. In our usage, does not include amounts that may be deducted from wages as the employee's contribution to premiums of a mandatory or voluntary health insurance program.

PRE-EXISTING CONDITION

A medical condition, existing at the time an individual enrolls in a health insurance plan, which the insurer refuses to cover, or refuses to cover for a fixed period of time (waiting period).

PREFERRED PROVIDER ORGANIZATION

Health service provider, or group of providers, which offer rate discounts or other concessions to a plan organizer or insurer. Some of these savings are passed on to the insured using the services of the PPO by reducing copayments or deductibles or expanding the list of covered services.

PRIMARY CARE

Package of basic health services which usually includes treatment and prevention of common infectious diseases (including vaccinations), prenatal care and delivery, well child care, treatment of minor injuries, management of routine chronic diseases

(asthma, diabetes, hypertension), and preliminary diagnosis of conditions requiring specialist diagnosis or surgical care. In developing countries, may refer to the restricted package of services which is available from first line health workers. In developed countries, usually includes the full range of services which can be obtained from a pediatrician, family practitioner, obstetrician and general internist.

PRIVATE (HEALTH) INSURANCE

Health insurance provided by an employer or purchased by an individual. Usually through the payment of a periodic premium to a licensed insurance company, or through a "self funding" arrangement where the employer pays directly the medical costs incurred by its employees. Excludes Social Security schemes and "mutuelles."

REPRODUCTIVE HEALTH

Spectrum of services provided to females including contraceptive services and supplies, treatment and prevention of sexually transmitted diseases, infertility treatment, prenatal care and safe delivery. May include services related to menopause and hormone replacement. Term indicates a broader focus than mere family planning, and is intended to assure the patient has a full range of reproductive choices.

RISK POOL

A group of individuals or households which, through the purchase of insurance or similar mechanism, share in the risk of health care costs. Risk pooling is designed to enable those who have lower health care costs in a given year to support costs for those who have higher medical needs in that year.

SOCIAL SECURITY (SOCIAL HEALTH INSURANCE)

A scheme in which the Government requires employers (and often employees) to contribute to a government managed pool of funds which provides health care services (as well as pension and disability benefits) for enrolled individuals. Usually limited to the formal sector in more developed countries. Services may be provided through facilities owned by the Social Security agency, through contractual payments to health care providers, or through sickness funds or other organizations which obtain health benefits for enrolled members using funds collected and transferred from the Government Social security agency.

THIRD PARTY ADMINISTRATOR (TPA)

An organization which manages health insurance plans but does not take risk. The TPA is paid by the employer or group establishing the plan and provides services including calculating required premiums, processing claims, negotiating provider contracts, and determining benefits and exclusions in covered services.

VOLUNTARY HEALTH INSURANCE

Health insurance policy purchased by an individual or family without government compulsion. In our usage, such policies are not part of an employer or group purchased insurance program, although the term is used elsewhere to refer to employer sponsored plans which supplement mandatory health insurance or Social Security.

Appendix B — List of Participants

MODERATOR

RICH FEELEY, *Boston University School of Public Health*

Mr. Feeley is a well-known expert in the field of international legal/policy reform, health care reform and health financing. A graduate of the Woodrow Wilson School of Public Affairs (Princeton) and Yale Law School, Mr. Feeley is a clinical Associate Professor at Boston University School of Public Health.

PANELISTS

DR. CHRIS ATIM, *Regional Advisor for West and Central Africa, PHR, Abt Associates*

Dr. Atim has worked all over Africa as a health economist, with particular emphasis on research, training and technical advice on community based and mutual health insurance activities. Dr. Atim is the author of several books and articles on mutual health organizations in Africa. Currently he is serving as the regional advisor for Partnerships for Health Reform (PHR) project in West and Central Africa.

LORI McDOUGAL, *Vice President, International Operations, United HealthCare Services, Inc.*

United HealthCare is a global, \$20B healthcare company with large-scale implementation experience in over 10 countries. They are the third largest HMO in the US and provide health care services to over 30 million Americans. Since 1983 Ms. McDougal has been responsible for the management of corporate operations for UnitedHealthcare's international private insurance programs. She also serves as Program Director for a master contract with the U.S. Department of Defense providing consulting and analysis for the global military health care system.

SCOTT AEBISCHER, *Vice President, HealthPartners*

HealthPartners is a nonprofit family of Minnesota health care organizations and plans focused on improving the health of its members and the community. HealthPartners is member-governed and provides health care services, insurance, HMO coverage and health plan administrative services to its members. HealthPartners is responsible for serving approximately 800,000 members through a service center of 140 staff utilizing e-commerce, face-to-face and state of the art telecommunications systems.

HealthPartners has worked in Uganda with Land O'Lakes through USAID and the Ugandan Ministry of Health to implement affordable prepayment healthcare schemes. In addition HealthPartners is collaborating with CMS to design and implement community based financing programs in Uganda.

DR. BEATRIZ ZURITA, *Executive Coordinator, FUNSALUD – Mexico*

Dr. Zurita has facilitated discussions and negotiations between the government of Mexico (Ministry of Finance, Ministry of Health, Social Security Institute), the legislature (House of Representative and the Senate) and the private sector (CCE) on issues such as the opting-out of social security, the proposed amendments to the General Insurance Law and the proposed amendments to Social Security Law and more recently the specific rules for the operation of new health insurance entities. At the same time Dr. Zurita is responsible for the supervision of technical work related to up-dating the data on the performance of the Mexican health System within FUNSALUD. Dr. Zurita also supervises the development of specific health systems and research projects.

Between 1996 and 1998 Dr. Zurita was health Policy Coordinator within FUNSALUD. In this capacity Dr. Zurita advised the Social Security Institute of Mexico (IMSS) on the opting-out of social benefits for IMSS. At that time FUNSALUD collaborate with Partnerships for Health Reform (PHR) in the estimation of the National Health Accounts for 9 countries, a project financed by USAID.

LORD ANDREW ENNISKILLEN, *CEO, AAR Health Services, Ltd – Kenya*

AAR Health Services, Ltd. (formerly Africa Air Rescue) is a privately owned managed healthcare organization built and developed in Kenya for the East African region. The organization is primarily a staff model HMO employing some 40 doctors and 130 nurses, paramedic, laboratory and pharmacy technicians. AAR Health Services delivers primary care through its own purpose built health centers in Kenya, Uganda and Tanzania. AAR also operates hospitalization and EMS services worldwide through partnership alliances with providers.

The company started an EMS organization 16 years ago but over the last 10 years has developed into the organization it is today through focusing on the customer need. AAR did not set out to copy the American HMO system but has developed into something that closely resembles it. AAR has attained a widely recognized and respected brand image and reliability and a market leadership position in the East African region. Lord Andrew Enniskillen is the Managing Director and CEO of AAR Health Services, Ltd

DR. MANUEL LOWENHAUPT, *Partner, Deloitte Consulting*

Dr. Lowenhaupt leads the Care Management segment of the Information Technology practice. Based in Deloitte's Boston office, Dr. Lowenhaupt is internationally noted for his work in Clinical Effectiveness, Care Management, Physician Performance Management and Clinical Informatics. His work has included redesign of care delivery systems in greater than one hundred twenty organizations in the U.S., Canada, Europe and the Far East. He has led projects in the United Kingdom, Norway, Sweden, Italy, Malaysia, Hong Kong, New Zealand, Singapore, Indonesia and Puerto Rico.

PARTICIPANTS

DUFF GILLESPIE, *Director, Center for Population Health and Nutrition — USAID*

MARGARET NEUSE, *Director, Office of Population — USAID*

KATHARINE KREIS, *CTO, Commercial Market Strategies Project — USAID*

ISABEL STOUT, *Senior Technical Advisor, Commercial Market Strategies Project — USAID*

SIGRID ANDERSON, *Chief, Family Planning Services Division, Office of Population — USAID*

MICHELLE MALONEY-KITTS, *Chief, Family Planning Services Division, Office of Population, USAID*

LIZANN PROSSER, *Director, Commercial Market Strategies*

DR. CARLOS CUÉLLAR, *Deputy Director, Commercial Market Strategies*

SUSAN MITCHELL, *Director of Country Programs, Commercial Market Strategies*

DR. DAN KRESS, *Research Director, Commercial Market Strategies*

CARLOS CARRAZANA, *Director, Summa Foundation*

DR. PETER COWLEY, *Country Representative, Commercial Market Strategies — Uganda*